MEDI-CAL UPDATE Part 2
Billing and Policy
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Standing Systems and Standing Frames

Standers and standing frames to allow wheelchair dependent patients to achieve a passive standing position are Medi-Cal benefits subject to prior authorization. The equipment is billed with HCPCS codes E0637 (combination sit to stand system, any size, with seat lift, with or without wheels) or E0638 (standing frame system, any size with or without wheels).

Medical Necessity
Standers and standing frames are considered medically necessary when there is documentation of the following:

- The device would allow the recipient to become more independent in one or more of the activities of daily living, and
- For a recipient with a pressure sore, the device would provide pressure relief/off-loading of the pressure sore that cannot be accomplished by other means, or
- Lower body strength is increased by maintaining a standing position for recipients with spastic quadriplegia or other neuromuscular conditions who are unable to rise from a seated to standing position without assistance and have some residual strength in the hips or legs, or
- Lower body strength is increased by maintaining a standing position for recipients with paraplegia and other neuromuscular conditions who are unable to rise from a seated to a standing position without assistance and have some residual strength in the hips or legs, and
- There is documentation that the recipient has tried the system through an ongoing outpatient therapy program and the physical therapist has witnessed the use of the system and recommends it.

Standers and standing frames are not considered medically necessary for recipients with complete paralysis of the hips and legs, such that lower body range of motion is not improved or maintained by the standing position, or if using the stander/frame would create an unsafe situation for the recipient.

Prescribing Physician
When ordering standing equipment billed with codes E0637 or E0638, the prescribing physician must provide medical documentation that the recipient has had sufficient training with the system and does not have a fracture risk or does not develop vertigo or become nauseous by standing. The prescribing physician must also document that the recipient is willing and able to stand and that there are suitable facilities and assistance available (when needed) in the recipient's home for standing.

TAR Requirements
Prior authorization (*Treatment Authorization Request*) may be approved only for those recipients who have had an adequate case management assessment of their overall needs for ambulation, positional changes and other essential activities of daily living, including an onsite evaluation as necessary.

Please see **Standing Systems**, *page 2*

Standing Systems *(continued)*

TARs requesting authorization of HCPCS codes E0637 or E0638 must include the following information.

- Diagnosis, age, height and weight, or other information regarding size
- Description of functions (sitting ability, standing ability, mobility)
- Description of transfers, functional goals, current program directed toward functional goals
- Daily activities, relevant impairment (range of motion, bowel/bladder/intestinal function, history of fractures or risk for bone density issues, respiratory status).

Additionally, the TAR must provide answers to the following questions answered by providers for review by Medi-Cal TAR field office personnel.

- What is the recipient's history of standing or efforts to stand?
- What is the recipient's current standing program? Does the recipient stand in any other setting (school, work setting, etc.)?
- Is the recipient able to stand by any method other than a stander (against furniture, with assist of caregiver, with a strap or support, with a walker, etc.)?
- How is the use of a stander related to the functional goals for this recipient?
- What specific activities for this recipient require a stander?
- Is there a home program or therapy program that requires regular use of a stander?
- Has this recipient experienced a trial of the proposed stander or any other stander and what were the results?
- What other standing devices were considered, and why were they rejected?
- What other less costly alternatives were considered, and why were they rejected (other approaches to identified needs – range of motion, stretching, splints, respiratory activities, other methods of weight-bearing, etc.)?

Rental Trial Period
A three-month rental period is mandatory before purchase of any stander/standing frame unless the beneficiary has participated in a community program of standing three to four times per week, for at least three months.

This information is reflected on manual replacement page dura bil dme 19 (Part 2).

Remittance Advice Details (RAD) Claim Denial Billing Tips

In an effort to assist Medi-Cal providers to receive expedited claims processing and reimbursement, EDS has developed helpful billing tips for the following Remittance Advice Details (RAD) claim denials:

RAD code 9098: The attached documentation is invalid.

- Check your catalog page to ensure that it contains the manufacturer's name and date of availability.
- If you have Durable Medical Equipment that was not available prior to August 1, 2003:
  - Indicate the date of availability in the *Reserved For Local Use* field (Box 19) of the claim or handwrite the date on the catalog page or invoice.
  - Indicate the statement, "new product" in the *Reserved For Local Use* field (Box 19) of the claim or handwrite it on the catalog page or invoice.

Please see **Billing Tips**, *page 3*

Billing Tips *(continued)*

  - Attach the manufacturer's price list and/or order form or the catalog page that initially published the item being billed on the claim.
  - Ensure that the Manufacturer's Suggested Retail Price (MSRP) is on the catalog page.
- If the manufacturer name or date is missing from the page, send a copy of the cover or back page of the catalog showing the effective date.
- It is acceptable to handwrite on the invoice or catalog page (for example, circling, drawing an arrow, underlining, or indicating the line number). Your claim will be denied if the invoice or catalog page is altered (for example, covering information or marking out information such as dealer cost or discounts).
- You may receive denial message 9098 if an item indicates zero payment on your invoice.

RAD code 9654: Manufacturer invoice and catalog page is required.
- For claims for non-wheelchair DME "By Report" codes, provide the following information with the claim:
  - The manufacturer's purchase invoice, indicating your cost, and the manufacturer's catalog page, showing the retail price dated prior to August 1, 2003. If the item was not available prior to August 1, 2003, attach a manufacturer's purchase invoice and the catalog page that initially published the item and the MSRP.
  - The item description
  - The manufacturer's name
  - The model number or catalog number
  - The reason a listed code was not used

RAD code 9006: This medical supply is not payable without a copy of the supplier's invoice.
- Verify that the invoice indicates your cost.
- Make sure that the invoice is dated prior to the date of service indicated on the claim.

RAD code 225: This is an incorrect procedure code and/or modifier for this service. Please resubmit.
- Verify the service code billed. You may have used an unlisted code when a listed code is available. Please check the *Durable Medical Equipment (DME): Billing Codes and Reimbursement Rates* section in the Part 2 manual.
- Verify the modifier code billed. You may have used an incorrect modifier. Please see the *Modifiers: Approved List* section in the Part 2 manual.
- When billing for the purchase of wheelchair batteries, use modifier -NU only.

Ensure your code(s) and modifier(s) on the claim match the *Treatment Authorization Request* (TAR)/*Service Authorization Request* (SAR)/eTAR.

Reminders:
When you bill with a listed code (a code with a price on file):
- An invoice or catalog is not required with your claim.
- The claim does not require manual pricing.
- The claim can be billed electronically.

Please use only black ink when completing your claim form or marking on documentation attached to the claim. Please do not use a highlighter on attachments.

If you have any questions, please call the Telephone Service Center (TSC) at 1-800-541-5555. Choose the applicable language and then select options 16, 14, and 11 (in the order listed) to reach the DME Questions line.

Secondary Diagnosis Codes for Incontinence Supply Products Updates

The following updates for billing incontinence supply products are effective for dates of service on or after December 1, 2005:

- ICD-9 code 788.38 (overflow incontinence) is added to the list of codes accepted as the secondary diagnosis.
- ICD-9 code 788.3 (urinary incontinence) is removed from the list of acceptable secondary diagnosis codes, and will be denied if included on claims.

The updated information is reflected on manual replacement page hcfa comp 13 (Part 2).

Intermittent Catheters with Attached Collection Bags Restriction Update

Effective for dates of service on or after December 1, 2005, the Code 1 restriction for Astra Tech and Coloplast products billed with code 9943N (intermittent catheters with attached collection bags) is limited to patients 18 years of age and under. *This information is reflected on manual replacement pages mc sup lst4 8 and 10 (Part 2).*

Provider Certification Statement Requirement

Providers were informed in a recent *Medi-Cal Update* that medical supply claims submitted with invoices containing disclaimers that affect Medicare/Medi-Cal reimbursement or with insufficient pricing documentation would be denied.

In accordance with this policy, providers are required to submit a self-certification that the invoice pricing on a medical supply claim is accurate and does not contain hidden charges that are not billable to Medi-Cal. The ability to self-certify allows providers to submit invoices with claims that the Department of Health Services would otherwise reject as invalid. Providers are not required to include this certification on every invoice, only those that contain statements mentioning added charges, fees, cost to invoice prices, or otherwise state that charges or fees included on the invoice may be hidden.

Providers are required to include the following certification statement written exactly as follows:

"I certify that I have properly disclosed and appropriately reflected a discount or other reduction in price obtained from a manufacturer or wholesaler in the costs claimed or charges on this invoice identified by item number _____ as stated in 42 U.S.C. 1320a-7b(b)(3)(A) of the Social Security Act and this charge does not exceed the upper billing limit as established in the *California Code of Regulations* (CCR), Title 22, Section 51008.1 (a)(2)(D)."

This information is reflected on manual replacement page mc sup 3 (Part 2).

CMC Claim Submission for Medicare/Medi-Cal Crossover Billers

Medi-Cal can now receive electronic crossover claims directly from approved submitters via the ASC X12N 837 v.4010A1 transaction. Submitters using the 837 format must include Medicare payment information at the detail/claim line level. Additionally, Medi-Cal can receive electronic crossover claims automatically from Mutual of Omaha and United Government Services Medicare intermediaries for most Part B services billed to Part A intermediaries. This new provision primarily affects outpatient and dialysis providers who were previously required to bill these claims on paper. Providers of Part B services billed to Part A intermediaries other than Mutual of Omaha and United Government Services must continue to bill their claims directly to Medi-Cal either on paper or in the new HIPAA standard 837 electronic transaction until a new automatic crossover process is established with the Medicare Consolidated Coordination of Benefits Contractor sometime in 2006.

Please see **CMC Claim Submission**, *page 5*

CMC Claim Submission *(continued)*

In order to comply with HIPAA electronic standards, providers billing crossover claims on paper for Part B services billed to Part A intermediaries will be required to attach the detail/claim line level *National Standard Intermediary Remittance Advice* (Medicare RA) to a *UB-92 Claim Form* and comply with revised billing instructions. Any claims received after October 24, 2005 that do not comply with the new billing and attachment requirements will be returned to providers for correction before processing.

Providers may obtain detailed Medicare RAs by printing the "Single Claim" report, which can be accessed through the latest version of PC Print software, available free of charge. PC Print software and instructions are available on the United Government Services Web site (**www.ugsmedicare.com**) by clicking "Providers," then "EDI" and then the "PC Print Software" link. Providers should obtain the PC Print software from Medicare as soon as possible to ensure they can print the appropriate Medicare RAs.

2006 ICD-9-CM Diagnosis Code Updates

The following diagnosis code additions, inactivations and revisions are effective for claims with dates of service on or after January 1, 2006. Providers may refer to the *2006 International Classification of Diseases, 9th Revision, Clinical Modifications, 6th Edition* for ICD-9 code descriptions.

Additions

259.50	276.50	276.51	276.52	278.02	287.30	287.31
287.32	287.33	287.39	291.82	292.85	327.00	327.01
327.02	327.09	327.10	327.11	327.12	327.13	327.14
327.15	327.19	327.20	327.21	327.22	327.23	327.24
327.25	327.26	327.27	327.29	327.30	327.31	327.32
327.33	327.34	327.35	327.36	327.37	327.39	327.40
327.41	327.42	327.43	327.44	327.49	327.51	327.52
327.53	327.59	327.8	362.03	362.04	362.05	362.06
362.07	426.82	443.82	525.40	525.41	525.42	525.43
525.44	525.50	525.51	525.52	525.53	525.54	567.21
567.22	567.23	567.29	567.31	567.38	567.39	567.81
567.82	567.89	585.1	585.2	585.3	585.4	585.5
585.6	585.9	599.60	599.69	651.70	651.71	651.73
760.77	760.78	763.84*****	770.10*****	770.11*****	770.12*****	770.13*****
770.14*****	770.15*****	770.16*****	770.17*****	770.18*****	770.85*****	770.86*****
779.84*****	780.95	799.01	799.02	996.40	996.41	996.42
996.43	996.44	996.45	996.46	996.47	996.49	V12.42
V12.60	V12.61	V12.69	V13.02	V13.03	V15.88	V17.81
V17.89	V18.9	V26.31	V26.32	V26.33	V46.13	V46.14
V49.84	V58.11	V58.12	V59.70**§**	V59.71****§**	V59.72****§**	V59.73†**§**
V59.74†**§**	V62.84	V64.00	V64.01	V64.02	V64.03	V64.04
V64.05	V64.06	V64.07	V64.08	V64.09	V69.5	V72.42**§**
V72.86	V85.0††	V85.1††	V85.21††	V85.22††	V85.23††	V85.24††
V85.25††	V85.30††	V85.31††	V85.32††	V85.33††	V85.34††	V85.35††
V85.36††	V85.37††	V85.38††	V85.39††	V85.4††		

Restrictions

***** Restricted to ages 0 thru 1 year
****** Restricted to ages 10 thru 35 years
† Restricted to ages 35 thru 55 years
†† Restricted to ages 18 thru 99 years
§ Restricted to females only

Please see **ICD-9 Updates**, *page 6*

ICD-9 Updates *(continued)*

Inactive Codes
Effective for dates of service on or after January 1, 2006, the following ICD-9 diagnosis codes are no longer reimbursable:

276.5, 287.3, 567.2, 567.8, 585, 599.6, 770.1, 799.0, 996.4, V12.6, V17.8, V26.3, V58.1, V64.0

Code Description Revisions
The descriptions of the following ICD-9 diagnosis codes are revised:

285.21, 307.45, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93, 728.87, 780.51, 780.52, 780.53, 780.54, 780.55, 780.57, 780.58

All manual replacement pages reflecting these ICD-9 code updates will be included in future *Medi-Cal Updates*.

Inpatient Provider Cutoff Date for Proprietary and Non-HIPAA Standard Electronic Claim Formats: December 1, 2005

In accordance with efforts to comply with the federally mandated Health Insurance Portability and Accountability Act (HIPAA), Medi-Cal is planning to discontinue acceptance of proprietary and non-HIPAA standard electronic formats for electronic claim transactions. The first provider community to be affected is the Inpatient provider community.

Beginning **December 1, 2005,** proprietary and non-HIPAA standard electronic claim formats submitted by Inpatient providers will no longer be accepted.

Self-Service HIPAA Transaction Utility Tool
A self-service environment, HIPAA Transaction Utility Tool, will soon be available for submitters. Initially, the utility tool will be available only for inpatient submitters to validate ASC X12N 837 v.4010A1 transactions in preparation for proprietary format discontinuance. However, the utility tool will become available to other submitter communities as their timeline for proprietary format discontinuance is determined.

The utility tool will offer transaction validation (inclusive of Companion Guide-level editing), troubleshooting and reporting features that enhance, but do not replace, Medi-Cal's current testing and media activation requirements. Inpatient submitters have been notified of the utility tool's availability via e-mail or letter depending on information availability.

Providers may call the Telephone Service Center (TSC) at 1-800-541-5555 for more information.

Cutoff dates for non-HIPAA standard claim formats for all other provider communities will be announced in upcoming *Medi-Cal Updates*.

Instructions for Manual Replacement Pages — Part 2

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Remove and replace:	*Contents for Durable Medical Equipment and Medical Supplies Billing and Policy iii/iv* *
	dura bil dme 1/2 *
Remove:	dura bil dme 19/20
Insert:	dura bil dme 19 thru 22 (new)
Remove and replace:	hcfa comp 13/14
	mc sup 3/4
	mc sup ex 3 thru 6 *
	mc sup lst4 7 thru 10

* Pages updated due to ongoing provider manual revisions.